MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02290

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A.A. Co. Stoney Creek
City or town Solley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A. Co.
City or town Stoney Creek Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Zigmund Aleksandrowicz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
58			... hrs. ... min.

9. Birthplace Poland (Town, county, and state)
10. Usual occupation Tailor
11. Industry or business
FATHER 12. Name Julius Alexandrowicz
13. Birthplace Poland
MOTHER 14. Maiden name Victoria
15. Birthplace Poland
16. Informant Joseph Alexandrowicz
Address 2905 Eastern Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/2/46 (month) (day) (year)
Cemetery or crematory Holy Rosary
Location Balto. Md.
18. Funeral director Wm. S. Fialkowski
Address 2007 Eastern ave
19. 4/1 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1946, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1946, to March 29 1946
and that I last saw h... alive on March 29 1946

Immediate cause of death	DURATION
(a) Myo Cardial Insufficiency	Days Weeks
Due to (b) Chronic Nephritis	Long Time
Due to (c)	
Other conditions Hypertension	Long Time

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Leon D. Hedrick M.D. M. D. or other
Address 760 Flemington Balto. Md. Date signed 3/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02291 [illegible] 0

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Anne Arundel

City or town Galesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mabel Simms Barnett

3. (b) Social Security Number ? None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	single

6.(b) Name of husband or wife Thomas Barnett ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
22			..... hrs. ..... min.

9. Birthplace Upper Marlboro Md (Town, county, and state)

10. Usual occupation None

11. Industry or business "

FATHER

12. Name Percy Simmons

13. Birthplace Croom Md.

MOTHER

14. Maiden name Agnes Belt

15. Birthplace Marlboro Md

16. Informant Lurencia Belt

Address Upper Marlboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 4th 1946 (month) (day) (year)

Cemetery or crematory Catholic

Location Upper Marlboro Md

18. Funeral director T. A. Hardesty & Son

Address Galesville Md

19. Apr 4th 1946 (Date rec'd by registrar) H. R. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH about March 21 1946, at ? M

21. I CERTIFY that death occurred on the date above stated: ~~Last attended deceased from~~ Post mortem Examination

~~and that I last saw him alive on~~ April 3 1946

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? accident Date of 3/21/46

Where did injury occur? Galesville (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?) tent house Creek

Means of injury Drowning Injured at work? no

23. SIGNATURE John M. Caffrey M.D. Deputy medical examiner M. D. or other

Address Annapolis, Md. Date signed 4/3/46

(M) MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

02292

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 1 month, 28 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 years, 1 month, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BENNETT - MARY

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single ?

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1905

8. AGE:	Years	Months	Days	If less than one day
	41	unknown		---- hrs. ---- min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: George Bennett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily ?
15. Birthplace: Washington, D. C.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-26-46 (month) (day) (year)
Cemetery or crematory: Stockton Cemetery
Location: Stockton, Md.

18. Funeral director: Irvin Bennett
Address: Stockton Md.

19. March 25, 19 46 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 19 46, at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26, 19 43, to March 24, 19 46, and that I last saw her alive on March 23, 19 46.

Immediate cause of death	DURATION
Tuberculosis of Lungs	Known to us since 2/4/46
Due to: ---	
Due to: ---	
Other conditions: Mental Deficiency with Psychosis - Imbecile (Include pregnancy within 3 months of death)	Known to us since 1/26/43

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert J. Thompson M. D. or other
Address: Crownsville, Maryland Date signed: 3/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02293

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Randall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Christina Ann Bollman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	White	Widow

6.(b) Name of husband or wife Burton Bollman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 24th 1865 1885

8. AGE:

Years	Months	Days	If less than one day
60	7	13	..... hrs. ..... min.

9. Birthplace Ellicott City Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name George E. Ruff
13. Birthplace Maryland
MOTHER 14. Maiden name Mary E. Davis
15. Birthplace Maryland.
16. Informant Mrs John Talton
Address 10 Randall St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 12 1946 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.
19. March 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1946, at 5-15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946, to March 9 1946
and that I last saw h.. alive on March 9 1946

	DURATION
Immediate cause of death Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions Arteriosclerosis, Hypertension	unknown, unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gunnell Boul M. D. or other
Address Annapolis Md. Date signed 3-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

ANNE ARUNDEL COUNTY HEALTH DEPARTMENT

ANNAPOLIS, MARYLAND

March 11, 1946

TO: Dr. Hedrich
FROM: Miss Whitney

Mr. Taylor called and said the date of birth on the death certificate of CHRISTINA ANN BOLLMAN should be 1885 and not 65. He did not have any hne available to send in to correct it.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 02294

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Larkwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Jacob Brooks

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Reba
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years: 49 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Grocery
FATHER 12. Name: Jacob Brooks
FATHER 13. Birthplace: Lith.
MOTHER 14. Maiden name: Mabie
MOTHER 15. Birthplace: Lith.
16. Informant: Wife
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-46 (month) (day) (year)
Cemetery or crematory: Aitz Chapel
Location: Work. Blvd.
18. Funeral director: Jack Lewis Inc
Address: 1439 E. Balto St.
19. 3/6 19 46 (Date rec'd by registrar) A-W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 5 19 46, at 9 03 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 43, to Mar. 19 46
and that I last saw h. alive on Mar. 5 19 46

Immediate cause of death	DURATION
Cerebral hemorrhage	2 2 hrs.
Due to: hypertensive cardio-vascular disease	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A. Bozzuto M D
M. D. or other
Address: Annapolis Md Date signed 3/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02295

★ Reg. Dist. No. 26

1. PLACE OF DEATH: H. A.

County

City or town: Shadyside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. Ke

City or town: Shadyside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Paul Brooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1945

8. AGE: Years	Months	Days	If less than one day
2	1	3	hrs. min.

9. Birthplace: Shadyside (Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business:

FATHER — 12. Name: John Brooks

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Cazelly Dixon

15. Birthplace: Md

16. Informant: John Brooks

Address: Shadyside

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1946 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Churchton Md

18. Funeral director: J. T. Johnson

Address: Annapolis

19. Mar. 28 1946 (Date rec'd by registrar) D. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1946 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Feb. 1946, to 25 Mar. 1946

and that I last saw him alive on 19

Immediate cause of death	DURATION
Myocarditis	
Insufficiency	
Due to: Rheumatic fever	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson M.D.

M. D. or other

Address: Lothian Md. Date signed 3/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03132

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 7 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 616 West Fairmount Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BURRELL - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1875 ?

8. AGE: Years	Months	Days	If less than one day
71 ?	unknown		---- hrs. ---- min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----

FATHER
12. Name: Amos Burrell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Millie ?
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-13-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt Hospital
Address: Crownsville

19. 4/13/46 19 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 46 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 19 45, to March 22 19 46
and that I last saw him alive on March 22 19 46

Immediate cause of death	DURATION
Carcinoma of Lower Lip	Known to us since 8/10/45
Due to: --------	
Due to: --------	
Other conditions: General Paresis	Known to us since 8/10/45

(Include pregnancy within 3 months of death)

Major findings of operations: --------
Date of op.: ------
Autopsy results: --------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: -------- Injured at work? --------

23. SIGNATURE: Albert L. Amerman M. D. or other
Address: Crownsville, Maryland Date signed: 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

02296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. C.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
113 So. St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 So. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daisy V. Calhoun

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	Widow

6.(b) Name of husband or wife Wm. F. Calhoun
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21 1885

8. AGE: Years	Months	Days	If less than one day
60	8	1	..... hrs. ..... min.

9. Birthplace Annapolis (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Daniel H. Johnson
13. Birthplace Md
MOTHER 14. Maiden name Emily Thomas
15. Birthplace Md
16. Informant Sophia Johnson
Address 113 So. St. Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 25/46 (month) (day) (year)
Cemetery or crematory Bruce Hill
Location Annapolis
16. Funeral director J. B. Johnson
Address Annapolis
19. March 25 19 46 (Date rec'd by registrar) O. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22 19 46 at 3.30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 19 46 to March 22 19 46
and that I last saw h.er alive on March 22 19 46

Immediate cause of death	DURATION
Apoplexy	2 dys.
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE J. B. Johnson M.D.
M. D. or other
Address 45 Northwest Street Date signed 3/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02297 Reg. Dist. No. 23

1. PLACE OF DEATH:

County: A. A.

City or town: Linthicum Hts.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Linthicum Hts.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 327 Maple Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Mosher Chapman

3.(b) Social Security Number: 213-05-6217

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Va. Butler Chapman

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): March 29 - 1872

8. AGE: Years	Months	Days	If less than one day
73	11	25	...hrs. ...min.

9. Birthplace: Elyria Ohio
(Town, county, and state)

10. Usual occupation: Chemist

11. Industry or business: Chemical Works
Brookline

FATHER — 12. Name: James Chapman

FATHER — 13. Birthplace: N. Y.

MOTHER — 14. Maiden name: Margaret Darling

MOTHER — 15. Birthplace: N. Y.

16. Informant: Mrs. Virginia Chapman

Address: 327 Maple Ave., Linthicum Hgts., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/46 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 3/26 1946 (Date rec'd by registrar) A. W. Hedrick Registrar
DM

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1938 to Mar. 24 1946 and that I last saw him alive on March 24 1946

Immediate cause of death	DURATION
Cardio-Vascular Disease	6 yr.
Due to	
Due to	
Other conditions: Grippe & Virus Pneumonia	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Chas. L. Ball M.D. (M. D. or other)

Address: Linthicum ...Date signed: 3-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02298

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: 216 Severn Ave. Eastport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Ann Arundel
City or town: 216 Severn Ave. Eastport.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Gertrude Chase

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Joseph Chase
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1903

8. AGE: Years	Months	Days	If less than one day
42	II		hrs. min.

9. Birthplace: Parole, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: Richard Galloway
13. Birthplace: Md.
MOTHER 14. Maiden name: Jennie Diggs
15. Birthplace: Md.
16. Informant: Joseph Chase
Address: Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14, 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis, Md.
19. March 14, 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1946, at 5:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1946, to March 11, 1946
and that I last saw h[illegible] alive on March 11, 1946

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R.H. Richardson M. D.
Address: [illegible] Date signed: 3/13/46

VS A15 9-45 1M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

02299

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 year 15 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 year, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: CORNISH - HESTER

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years	Months	Days	If less than one day
74	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewrok
11. Industry or business: -------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Sarah ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal, Which?: burial Date thereof: 3/20/46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.

18. Funeral director: Supt.
Address

19. (Date rec'd by registrar) March 13 1946 E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26 1944, to March 11 1946
and that I last saw her alive on March 11 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 2/26/44
Due to: -------	
Due to: -------	
Other conditions: Senile Psychosis	Known to us since 2/26/44

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: -----
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -----
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ------- Injured at work? -----

23. SIGNATURE: Harl V. Smithers M. D. or other
Address: Crownsville, Maryland Date signed: 3/11/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

02300

CERTIFICATE OF DEATH

★ Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A.
City or town: Dorsey (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: a. a.
City or town: Dorsey (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Dailey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 12th 1905

8. AGE: Years 41 | Months 1 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace: Dorsey, a. a. Co., Md. (Town, county, and state)

10. Usual occupation: Domestic.

11. Industry or business

FATHER
12. Name: Geo. Dailey
13. Birthplace: Dorsey, a. a. Co., Md.

MOTHER
14. Maiden name: Elvina Culver
15. Birthplace: a. a. Co., Md.

16. Informant: Arthur Dailey
Address: Dorsey, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/46 (month) (day) (year)
Cemetery or crematory: St. Marks
Location: Ridge Rd.

18. Funeral director: W. C. White Co. Inc.
Address: Laurel, Md.

19. Mar 26 1946 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1946 at 8 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 23 1946 to March 24 1946 and that I last saw h[illegible] alive on March 24 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	2 days.
Due to: Hypertension.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Shipley M. D. M. D. or other
Address: Savage, Md. Date signed 3/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

BC 02301 P

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: DANIELS - DAVID (John Doe)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): June 14, 1906

8. AGE: Years	Months	Days	If less than one day
39	8	27	---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: James E. Daniels
13. Birthplace: Heathsville, North Carolina

MOTHER
14. Maiden name: Eleanora Boone
15. Birthplace: Ringwood, North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar. 14, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Westport, Maryland

18. Funeral director: Mrs. Katie R. Williams
Address: 322 North Schroeder St., Balto., Md.

19. 3/14 19 46 A. E. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 19 46 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13 19 46 to March 11 19 46 and that I last saw him alive on March 10 19 46

Immediate cause of death	DURATION
General Paresis	Known to us since 2/13/46
Due to: ----------	
Due to: ----------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: -------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Herbert V. Schroeder M. D. or other
Address: Crownsville, Maryland Date signed: 3/11/46

VS A15 9-45-1M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

02302

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 25

Village or City Arnold No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Barbara A. Doyle

(a) Residence: No. Arnold, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	W.d.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Doyle

6. DATE OF BIRTH (month, day, and year) June 16, 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	8	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Germany (State or country)

FATHER

13. NAME Andrew Seifert

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Annie Popp.

16. BIRTHPLACE (city or town) Germany (State or country)

17. INFORMANT Family (Address) Arnold, Md

18. BURIAL, CREMATION, OR REMOVAL Place Cathedral Date 3-11, 1946

19. UNDERTAKER James L. McCully (Address) 130 E. Fairfax

20. FILED March 10, 1946 Ida M. Whalen Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 8, 1946 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Feb. 1943, to Mar. 8, 1946

I last saw h.. alive on ..., 1946; death is said to have occurred on the date stated above, at 11 30 m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Myocarditis	Few years
Hypertrophied Prostatectomy	
Arteriosclerosis	

Other **Contributory Causes** of importance: Chr. Nephritis, Interstitial unknown

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George C. Basil M. D.

(Address) Annapolis, Maryland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Dr. Charles L. Ball
203 West Maple Road
Linthicum Heights

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48@

CERTIFICATE OF DEATH

02303

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Brooklyn A.A.County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
700 Church Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Brooklyn A.A.County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 700 Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary A. Drinks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife James Lee Drinks
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1891

8. AGE: Years	Months	Days	If less than one day
54	2	14	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name John Mc Cormick
13. Birthplace Ireland

MOTHER
14. Maiden name Catherine Degnan
15. Birthplace Ireland

16. Informant Mr. James Lee Drinks
Address 700 Chruch Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 9, 46 (month) (day) (year)
Cemetery or crematory Holy Cross
Location Baltimore Co.

18. Funeral director Leonard J. Ruck
Address 5305 Harford Road-14-

19. 3/8 (Date rec'd by registrar) 19 46 A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th, 19 46 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 42 to March 5 19 46 and that I last saw her alive on March 5 19 46

Immediate cause of death	DURATION
Cancer - Cervix - (Adeno-Carcinoma)	18 mos.
Due to	
Due to	
Other conditions Hypertension	4 yr.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. MD M. D. or other
Address Linthicum Date signed 3-5-1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

0230 4

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years, 8 months
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 years, 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Brown
(If outside city or town limits, write RURAL and give nearest town)
Street No. ———
(If rural, give LOCATION)
unknown
2.(a) If veteran, name war

3.(a) FULL NAME EVANS - DANIEL

3.(b) Social Security Number ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): 1847

8. AGE: Years: 99 Months: unknown Days: If less than one day: ——— hrs. ——— min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ———

FATHER
12. Name: John Evans
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Fletcher
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 3/25-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Dept -
Address

19. Mar 26 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1946, at 5:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1932, to March 14 1946 and that I last saw him alive on March 13 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to: General Arteriosclerosis	
Due to: ———	
Other conditions: Senility	Known to us since 7/14/32

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Hal J. Edwards M. D. or other
Address: Crownsville, Maryland Date signed 3/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 145-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

02305

Reg. Diat. No. 27

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town FT GEO G MEADE, MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town POW AREA Ft GEO G MEADE, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war (Soldier, German Army)

3.(a) FULL NAME ERWIN FEIBER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Emilie Margane Lucka

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1910

8. AGE: Years 36 | Months 4 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Neumarkt, Germany
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant —

Address —

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/46 (month) (day) (year)

Cemetery or crematory Post Cemetery

Location Fort George G. Meade Md.

18. Funeral director Howard G. Blight Jr.

Address 4914 Belair Road.

19. 27 March 19 46 Fred D. Tollison
(Date received by registrar) FRANK D. TOLLISON, Capt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 March 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Asphyxiation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Asphyxiation

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 25 Mar '46

Where did injury occur? POW Area, (City or town) Ft. Geo G. Meade, (County) Md. (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Hanging Injured at work?

23. SIGNATURE Philip F. Flynn, 1st Lt M.C.
M. D. or other

Address Regional Hospital, Fort Meade, Md. Date signed 29 Mar '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02306

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 46 Pleasant st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 46 Pleasant St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Robert Gray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Josephine Gray
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Nov. 20 1892

8. AGE: Years	Months	Days	If less than one day
53	2	22	hrs. min.

9. Birthplace: Eastport Md. (Town, county, and state)
10. Usual occupation: U.S.N.
11. Industry or business
FATHER 12. Name: Jessie Gray
13. Birthplace: Md.
MOTHER 14. Maiden name: Lucy Lady
15. Birthplace: Md.
16. Informant: Josephine Gray
Address: 46 Pleasant St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/46 (month) (day), (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis
19. March 6, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 3 1946, at 7.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1946, to March 3, 1946
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Dis.	5 mon.
Due to: Hypertension	
Due to: Mitral Insufficiency	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Herbert H. Johnson M.D. M. D. or other
Address: 40 Northeast Street Date signed 3/5/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02367

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 yrs.
Hospital, institution, or street address where death occurred:
21 Obrine Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Obrine Court
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elnore Hebron

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widowed

6.(b) Name of husband or wife: John Hebron
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15, 1892

8. AGE: Years	Months	Days	If less than one day
53	9	7	..... hrs. ..... min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Ben Colbert
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden name: Ida Queen
15. Birthplace: Annapolis, Maryland

16. Informant: Richard Hebron
Address: 21 Obrine Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 24, 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended

18. Funeral director: Miss Mrs. Charles E. Hicks
Address: 45 Northwest Street

19. March 22, 1946 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1946, at 7 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1946, to March 21, 1946, and that I last saw h.. alive on March 20, 1946

Immediate cause of death	DURATION
Paralysis	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M. D. or other
Address: 12 Carroll St Date signed: 3-22-46

M. O'Connell

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02308

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Erin Lenore Hollinde

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 19 1944

8. AGE: Years	Months	Days	If less than one day
1	8	9	..... hrs. ..... min.

9. Birthplace Severna Park (Town, county and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name William J Hollinde

13. Birthplace New York City

MOTHER 14. Maiden name Elizabeth M Fox

15. Birthplace Michigan

16. Informant William J Hollinde

Address Severna Park, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 30/46 (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis, Md.

18. Funeral director B L Hopkins

Address Annapolis, Md.

19. March 30 19 46 (Date rec'd by registrar) W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 46 at 11 25 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Postmortem Examination to March 28, 19 46 and that I last saw him alive on

Immediate cause of death	DURATION
Fracture of Skull	
Due to Crushing injury	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/28/46

Where did injury occur? Manhattan Beach, A.A., Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on road near home

Means of injury Laundry truck ran over him Injured at work? Definite Needs

23. SIGNATURE John M. Claffy M.D., Examiner M. D. or other

Address Annapolis, Md Date signed 3/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02309

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL Co.
City or town: SEVERNA PARK, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
SEVERNA PARK, MD
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: M.D. County: ANNE ARUNDEL Co.
City or town: SEVERNA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY REBECCA HUPF

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: WILLIAM HENRY HUPF
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEB. 23 1897

8. AGE: Years	Months	Days	If less than one day
49	1	6	hrs. min.

9. Birthplace: HAGERSTOWN, MD.
(Town, county, and state)
10. Usual occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: CHRISTOPHER B. WEST
13. Birthplace: UNION, N.Y

MOTHER
14. Maiden name: SALLIE K. JAMES
15. Birthplace: HARTFORD Co, MD

16. Informant: MR. WILLIAM H. HUPF
Address: SEVERNA PARK, MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4/1/46 (month) (day) (year)
Cemetery or crematory: MT. OLIVET CEMETERY
Location: FREDERICK AVE.

18. Funeral director: JOHN F. DENNY INC.
Address: LIGHT + MONTGOMERY

19. 3-29 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 28, 1946, at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 - 1946 to Mar. 28 1946 and that I last saw her alive on Mar. 28 1946

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 mos.
Due to Coronis - Sclerosis	10 yr.
Due to Hypertension -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bale Jr. M.D. M. D. or other
Address: Linthicum Date signed: 9-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-M

1945 –
36 – 1936
9
9
45

02310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9(21)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton, Waugh Chapel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton, R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waugh Chapel
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Laurine January

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	(Widow).

6.(b) Name of husband or wife: Joseph Mc. January 6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): November 13, 1872

8. AGE:

Years	Months	Days	If less than one day
73	3	18	...hrs. ...min.

9. Birthplace: Guilford, Howard Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Louis Degraph
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: William L. January
Address: Odenton, Md R.F.D

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5 1946 (month) (day) (year)
Cemetery or crematory: Waugh Chapel
Location: Odenton, Md R.F.D.
18. Funeral director: Thomas W. Dungston
Address: Glen Burnie, Md.

19. 3/4 (Date rec'd by registrar) 1946 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 1946, to Mch 3 1946 and that I last saw h.. alive on March 3 1946

Immediate cause of death	DURATION
Coronary Thrombosis,	
Due to Hypertension,	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O. H. Mac Neuar, M. D. or other
Address: Millersville Md. Date signed: 3/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23 — 02311

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Marley Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Glenburnie Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Eva E. Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	Widow

6.(b) Name of husband or wife: Benj Johnson
6.(c) If alive, give age ..... years
7. Birth date of deceased: (Month) (Day) (Year) 12-1902

8. AGE — Years	Months	Days	If less than one day
44			hrs. min.

9. Birthplace: Harford Co. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER — 12. Name: John H. Jones
13. Birthplace: Harford Co Md
MOTHER — 14. Maiden name: Sarah Jane
15. Birthplace: Harford Co. Md
16. Informant: Elsie Bond
Address: Glenburnie Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20/46 (month) (day) (year)
Cemetery or crematory: Tabernacle Cem.
Location: Harford County
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave. Baltimore
19. March 18 19 46 (Date rec'd by registrar) M. DeAlva Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17-46, 19..., at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1-46 to March 17-46 and that I last saw h... alive on March 15-46

Immediate cause of death	DURATION
Acute Heart Failure	
Due to	
Due to	
Other conditions: Chronic Advanced Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. D. or other
Address: Glenburnie Md Date signed: March 18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

mrs de alba

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

02312

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A.A.
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
none
2.(a) If veteran, name war

3.(a) FULL NAME
Mr. Fritz Knopp.

3.(b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ida J. Knopp
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 14, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	7	...hrs. ...min.

9. Birthplace: Deale Md.
(Town, county, and state)

10. Usual occupation: Waterman
11. Industry or business: Sea food

FATHER
12. Name: Joseph Knopp
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Miller
15. Birthplace: Germany

16. Informant: Ida J. Knopp
Address: Deale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/46 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Lotjian, Md.

18. Funeral director: T.A.Hardesty & Son
Address: Galesville, Md.

19. Mar. 22 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1946 to March 21 1946 and that I last saw him alive on March 21 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other
Address: Lothian, Md. Date signed 3/22/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02313

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Millersville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Millersville R.F.D. #1 - Box 87
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Elvaton Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Koppold

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Pauline Koppold.
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): January 10, 1867

8. AGE:

Years	Months	Days	If less than one day
79	1	25	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Farming - (Retired)
11. Industry or business: Own Farm.

FATHER
12. Name: UNKNOWN
13. Birthplace: Germany

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: Germany

16. Informant: Mrs. Fred Schultz
Address: Millersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-46 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. March 5 1946 (Date rec'd by registrar) M. Talbert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1946 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1945 to March 4 1946
and that I last saw him alive on March 3 1946

Immediate cause of death	DURATION
Heart failure	2 days
Due to: Mitral Insufficiency	1 yr.
Due to: Arteriosclerotic Nephritis	Unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Gardner M.D. M. D. or other
Address: Glen Burnie Md. Date signed 3/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02314

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 9 days
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Md.
How long in hospital or institution? 3 months 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4212 Groveland Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: World Wars I and II ✓

3.(a) FULL NAME: LENTZ, George (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Friedel Lentz
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 18, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	26	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Captain, U.S.M.C. Ret., Inactive
11. Industry or business

FATHER
12. Name: Herman Lentz
13. Birthplace: Germany

MOTHER
14. Maiden name: Maria Konsteadt
15. Birthplace: Germany

16. Informant: U.S.Naval Hospital
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/18/46 (month) (day) (year)
Cemetery or crematory: Arlington U.S. National
Location: Arlington, Va.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 3/16 19 46 (Date rec'd by registrar) Geo Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 March 19 46 at 11:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Dec 19 45 to 14 March 19 46 and that I last saw h.. alive on 14 March 19 46

Immediate cause of death	DURATION
Hypernephroma Left	
Due to	
Due to	
Other conditions Metastasis to Liver & Lungs Aneurysm of Aorta (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results: HYPERNEPHROMA
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. J. Barbenik M.D. M. D. or other
Address: U.S.N.H. Annapolis Md. Date signed 3-15-46

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Recd VS
3/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

02315

Reg. Dist. No. 2-1

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours 10 minutes

Hospital, Institution, or street address where death occurred: Annapolis Emergency Hospital

How long in hospital or institution? 2 hours 2 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(If newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fort Meade Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alsey Lowman

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 4, 1873

8. AGE:

Years	Months	Days	If less than one day
72	10	24	hrs. min.

9. Birthplace: Odenton, Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Odd Jobs.

FATHER

12. Name: Richard Lowman

13. Birthplace: Odenton, Md

MOTHER

14. Maiden name: Caroline Hammond.

15. Birthplace: Odenton Md

16. Informant: Mrs. Wilbey Stevenson

Address: Glen Burnie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3 1946 (month) (day) (year)

Cemetery or crematory: Baldwin Memo. Ch. yd.

Location: Millersville Md.

16. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 3/2/46 (Date rec'd by registrar) Mabel Allen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1946, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946, to March 1 1946

and that I last saw h...l m... alive on March 1 1946

Immediate cause of death	DURATION
Acute Dilatation of Heart	3 days
Due to: Chronic Myocarditis	2 years
Due to: Arterial - Sclerosis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Duffy M.D. Deputy Medical Examiner M. D. or Coroner

Address: Annapolis Md Date signed: 3/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

CERTIFICATE OF DEATH

(*) 02345 20

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Lothian Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

Lothian Md.

How long in hospital or institution? ***************

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.

City or town Lothian Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. None

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Florence Magruder

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widow

6.(b) Name of husband or wife ***************

6.(c) If alive, give age *************** years

7. Birth date of deceased (mo., day, yr.) March 15, 1886

8. AGE: Years	Months	Days	If less than one day
60 60	***	16	hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name George Sharps

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Annie Thomas

MOTHER 15. Birthplace Calvert Co. Md.

16. Informant Bessie Magruder Peters

Address Lothian Md. A. A. Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1946 (month) (day) (year)

Cemetery or crematory Mt. Zion Church Cemetery

Location Lothian Md. A. A. Co.

18. Funeral director Mrs Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

19. April 4 1946 (Date rec'd by registrar) M. Clarke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 9:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1943, to March 31 1946

and that I last saw her alive on March 15 1946

	DURATION
Immediate cause of death Apoplexy	2 Mos.
Due to Hypertension	?
Due to Chronic Nephritis	
Other conditions Myocarditis Chronic	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. Hurst M. D. or other

Address Lothian, Md Date signed 3/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

02317

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) none
2.(a) If veteran, name war

3. (a) FULL NAME: Wade Hamilton Marshall

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie E. Marshall
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): June 14, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	23	hrs. min.

9. Birthplace: Eastern Shore, Md. (Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business

FATHER
12. Name: William Marshall
13. Birthplace: Md.

MOTHER
14. Maiden name: Fannie Marshall
15. Birthplace: Md.

16. Informant: Annie E. Marshall
Address: Deale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/46 (month) (day) (year)
Cemetery or crematory: St. James
Location: Tracey's, Md

18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Md.

19. Mar 10 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 46 at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to March 7 1946 and that I last saw h. alive on March 7 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	Few Days
Due to Thrombophlebitis of Left Femoral and	
Due to Intracellular	
Other conditions Myocarditis Chronic Nephritis Chronic	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F B Dent M. D. or other
Address: Pittsville, Md. Date signed 3-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02318

Reg. Dist. No. 28.

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: ~~Baltimore~~ (?)
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 North Caroline Street
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3. (a) FULL NAME: MAYS - CLINTON S.

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1927

8. AGE: Years: 18 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: April 3, 1946
(month) (day) (year)

Cemetery or crematory:

Location: Rocky Mount, North Carolina

18. Funeral director: Mrs. Geo. G. Kelson

Address: 1303 Presstman St., Balto., Md.

19. April 1946
(Date rec'd by registrar)
E. T. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1946, at 11:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 1946, to March 31, 1946

and that I last saw him alive on March 31, 1946

Immediate cause of death	DURATION
Tuberculus Meningitis	Known to us since 3/29/46
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 3/31/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 3 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02519

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 hrs

Hospital, institution, or street address where death occurred: Telegraph Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. Telegraph Rd. Severn Md. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Banner Meade Banner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: X

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20 - 1946

8. AGE:

Years	Months	Days	If less than one day
		1	8 hrs. min.

9. Birthplace: Severn Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Logan Banner Meade

13. Birthplace: Va

MOTHER — 14. Maiden name: Charlotte Nash

15. Birthplace: Va

16. Informant: Logan B. Meade

Address: Telegraph Rd Severn Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: March 23-46 (month) (day) (year)

Cemetery or crematory: Glen Haven Mem.

Location: A.A. Co. Md.

18. Funeral director: E. Willis Lamprecau

Address: 4510 Liberty Hgts Ave

19. 3/22/46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1946 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20. 1946, to March 21 1946

and that I last saw him alive on March 21 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 hr.

Due to: Difficult Labor — at Home

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bagley Jr. M.D. or other

Address: Linthicum Date signed 3-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02320

CERTIFICATE OF DEATH

★ Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Selley - P.O. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One day

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town P.O. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. Selley

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Violet Jean Miller.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3/4/46 - at 11:55 A.M.

8. AGE: Years | Months | Days | If less than one day 23 hrs. ..... min.

9. Birthplace Selley - P.O. Glen Burnie (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name Henry Miller Jr.

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Verna Kinsley

15. Birthplace Pennsylvania.

16. Informant Mrs. Verna Miller (Mother)

Address Glen Burnie, Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-7-46 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 3/6 (Date rec'd by registrar) 19 46 Mae Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/4/46 19 to 3/5/46 19

and that I last saw her alive on 3/4/46 19

Immediate cause of death	DURATION
Atelectasis	Few hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Gustav A. Pancher M.D. M. D. or other

Address Glen Burnie, Md. Date signed 3/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

02321

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 909 Monroe St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frances Miner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife George Miner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
About 83			hrs. ..... min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual occupation Retired - Housewife
11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Annapolis Md.

MOTHER
14. Maiden name Mary G. Love
15. Birthplace A & A Co. Md.

16. Informant Miss Georgiana Thomas
Address 909 Munroe St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5-1946 (month) (day) (year)
Cemetery or crematory St Annes
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.

19. March 5 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1946 at 11-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 27 1946, to Mar. 2 1946
and that I last saw h.e.r. alive on Mar. 2 1946

Immediate cause of death	DURATION
Acute Cardiac Failure	sudden
Due to Cerebral arterio Sclerosis	2 years
Due to Hypertensive cardio vascular renal disease	unknown
Other conditions Cysts	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Cagley M.D. M. D. or other
Address Annapolis Md Date signed 3/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02322

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: P.O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Brookwood Grove
Hospital, Institution, or street address where death occurred: Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Augusta - 473
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mr. Harry Moore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Mrs. Rosella Westbrook
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 22 - 1884

8. AGE:

Years	Months	Days	If less than one day
61	3	4	..... hrs. ..... min.

9. Birthplace: Lyndenwood, N.J. (Town, county, and state)
10. Usual occupation: Clerk at the B. M. R. R.
11. Industry or business:
FATHER 12. Name: Albert Moore
13. Birthplace: New Brunswick, N.J.
MOTHER 14. Maiden name: Jemima Risler
15. Birthplace: Boxwood, N.J.
16. Informant: Mrs. H. Moore (wife)
Address: Brookwood Grove, P.O. Pasadena
17. Burial. (Burial, cremation, or removal. Which?) Date thereof 3/30/46. (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery.
Location: Baltimore - Md.
18. Funeral director: Charles J. Schwab
Address: 505 N. Monroe St.
19. 3/29/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 19 46 at 9:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute cardiac disease (Coronary Thrombosis)	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. A. Pambert M.D. (Physician, medical examiner, M. D. or other)
Address: Glen Burnie, Md. Date signed 3/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02323

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs

Hospital, Institution, or street address where death occurred:

214 Prince Geo St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Prince Geo

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie P Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	widow

6.(b) Name of husband or wife David Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 27 – 1860

8. AGE: Years 85 | Months 8 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace California (Town, county, and state)

10. Usual occupation merchant

11. Industry or business

FATHER 12. Name arthur Grellman

13. Birthplace Germany

MOTHER 14. Maiden name agnes Joerres

15. Birthplace Germany

16. Informant Mrs agnes Stroyeyer

Address 214 Prince Geo St Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 11 46 (month) (day) (year)

Cemetery or crematory St annes

Location annapolis md

18. Funeral director B F Hopkins

Address annapolis Md

19. March 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946 at 9 45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1946, to March 8 1946

and that I last saw h... alive on March 7 1946

	DURATION
Immediate cause of death Myocarditis & Myocardial degeneration	Several months
Due to Arteriosclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boarman M. D. or other

Address Annapolis Md Date signed 3-10-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

02324

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel.
City or town Pt. Pasadena, Magothy Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1019 - Hilburn St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Marcellus Pfister

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife Anne Cassilly.
6.(c) If alive, give age Dead. years

7. Birth date of deceased (mo., day, yr.) Nov. 15 - 1869

8. AGE:

Years	Months	Days	If less than one day
76	8	2.	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Painter.
11. Industry or business
FATHER 12. Name Not known
13. Birthplace "
MOTHER 14. Maiden name Not known
15. Birthplace "
16. Informant Wilbur L. Pfister (son)
Address Magothy Beach
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3-16-46 (month) (day) (year)
Cemetery or crematory Holy Cross Cem
Location A A Co
18. Funeral director Bernard E Harke
Address 121 E West St
19. 3/14 1946 A.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 1:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Heart failure	Sudden
Due to Nephritis.	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Pambert M.D. (Attending physician or other)
Address Glen Burnie Md. Date signed 3/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on Film No. 101 - March 20, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02325

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George W. Phipps

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Minerva Ann Phipps

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 5, 1867

8. AGE: Years	Months	Days	If less than one day
78 ~~79~~	10	5	hrs. min.

9. Birthplace Davidsonville, Md.
(Town, county, and state)

10. Usual occupation Carrenter Ret.

11. Industry or business

FATHER 12. Name Benjamin Phipps

13. Birthplace Maryland

MOTHER 14. Maiden name Anna Taylor

15. Birthplace Maryland

16. Informant Minerva Ann Phipps

Address Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13 46 (month) (day) (year)

Cemetery or crematory St Stephens

Location Millersville, A.A. Co., Md.

18. Funeral director Ben L. Hopkins

Address 170-172 West St. Annapolis, Md.

19. March 12 19 46 (Date rec'd by registrar)

W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 46, at 3 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 19 46 to Mar. 10 19 46

and that I last saw him alive on March 10, 19 46

Immediate cause of death	DURATION
Cardiac asthma	1 year
Due to, Chronic myocarditis	unknown
Due to, Oedema of lungs	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Cosby, M.D.
M. D. or other

Address Annapolis Md Date signed 3/11/46

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

02329

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A.A.

City or town Lauthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.

City or town Lauthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 E. Hill Top Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George H. Pierce

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Helen Mary Cook Pierce

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) June 10 - 1862

8. AGE:

Years	Months	Days	If less than one day
83	9	7	...hrs. ...min.

9. Birthplace Marion Co. Ohio

(Town, county, and state)

10. Usual occupation Clerk in Bank -

11. Industry or business Retired

FATHER 12. Name Geo. H. Pierce

13. Birthplace Ohio -

MOTHER 14. Maiden name [illegible]

15. Birthplace [illegible]

16. Informant Chas. L. Baer

Address 311 E. Hilltop Road

17. Cremation (Burial, cremation, or removal. Which?) Date thereof March 1946 (month) (day) (year)

Cemetery or crematory Loudon Park

Location 3501 Frederick Ave.

18. Funeral director John C. Whitehill & Sons

Address 1908 Eutaw Place

19. 3-18 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1940, to Mar. 17 1946 and that I last saw him alive on Mar. 17 1946

	DURATION
Immediate cause of death Uremia	4 Days
Due to Arteris-Sclerosis.	10 yr.
Due to	
Other conditions Poly Arthritis	15 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Baer Jr. M.D. M. D. or other

Address Lauthicum Date signed 3-18-1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

02327

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Bristol (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Mary Pindell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 3, 1864

8. AGE: Years	Months	Days	If less than one day
81	5	29	hrs. min.

9. Birthplace: Bristol, A. A. Co. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: Robert M. Pindell

FATHER — 13. Birthplace: Bristol, Md.

MOTHER — 14. Maiden name: Mary E. Drury

MOTHER — 15. Birthplace: Bristol, Md.

16. Informant: Mrs. Harriet Pindell

Address: Bristol, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4, 1946 (month) (day) (year)

Cemetery or crematory: Pindell Family Cemetery

Location: Bristol, Md.

18. Funeral director: J. A. Kinderdine & Son

Address: Edgewood, Md.

19. March 16 1946 (Date rec'd by registrar) W. D. Pownall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1946, at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Myocarditis Chronic	
(b) Due to Cerebral Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Md. Date signed 3/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

02328

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Bay Ridge
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bay Ridge
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Delia Schneider

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Ernest A. Schneider
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 14, 1856

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
89	6	25		

9. Birthplace: New York, N. Y.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: —

FATHER
12. Name: Charles Lecar
13. Birthplace: France

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. Marjorie Heath
Address: Bay Ridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 12, 1946 (month) (day) (year)
Cemetery or crematory: West Minister Cemetery
Location: Philadelphia, Penn.

18. Funeral director: John M. Taylor 3rd Son
Address: Annapolis, Md.

19. March 11 1946 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 9, 1946, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-9- 1946, to 3-9- 1946
and that I last saw her ALIVE on 3-9-46 1946

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to: Arterio-sclerotic Heart Disease	6 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Whara did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Marton, M.D.
M. D. or other
Address: 185 Prince George St. Annapolis, Md. Date signed: 3-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

02329

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P.G.
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Married

3.(a) FULL NAME Howard Beall

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 13 1930

8. AGE:

Years	Months	Days	If less than one day
16	1	8	..... hrs. ..... min.

9. Birthplace: Brandywine (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Ephrim Scott
13. Birthplace: Md

MOTHER
14. Maiden name: Sarah Brady
15. Birthplace: Md

16. Informant: Reggie Scott
Address: Galesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 4. 1946 (month) (day) (year)
Cemetery or crematory: Brandywine Cem
Location: Brandywine
18. Funeral director: E. A. Hayden & Son
Address: Galesville Md

19. Apr 5 1946 (Date rec'd by registrar) M. Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about March 21 1946, at ? M

21. I CERTIFY that death occurred ~~on the~~ date above stated; ~~that I attended deceased from~~ Postmortem Examination 19..... ~~and that I last saw him alive~~ on Apr. 3 1946

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 3/21/46
Where did injury occur? Galesville (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Tent house Creek
Means of injury Drowning Injured at work? No

23. SIGNATURE: John M. Claffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 4/3/46

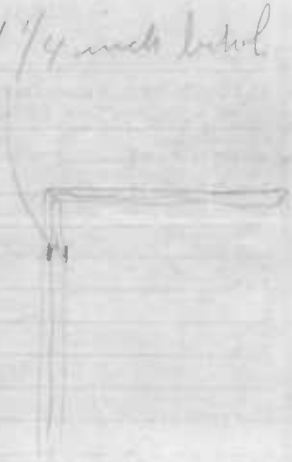
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-6X5·0
X0·4

1¼ inch bolt



03133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2400

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Conduit Street
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Barbara Ann Shinholser

3.(b) Social Security Number —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): September 23d 1939

8. AGE: Years 6 Months 5 Days 25 If less than one day ... hrs. ... min.

9. Birthplace: Annapolis - A. A. Co. - Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Jack T. Shinholser
13. Birthplace: Elko - Georgia

MOTHER
14. Maiden name: Anna Mace
15. Birthplace: Annapolis, Md.

16. Informant: Jack T. Shinholser
Address: 117 Conduit St. Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 21st 1946 (month) (day) (year)
Cemetery or crematory: St Ann's Cemetery
Location: Annapolis Maryland
18. Funeral director: John M. Taylor & Son
Address: Annapolis, Maryland

19. March 21 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 18 1946, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 17 1946, to Mar 18 1946 and that I last saw her alive on Mar. 18 1946

Immediate cause of death	DURATION
septicemia; duration 2 days exp.	31 hrs
Due to: type unknown. Cause of the septicemia not determined.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] Md — M. D. or other
Address: Annapolis Md Date signed 3/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

02330

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Md.
How long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: South Dakota County:
City or town: Platte
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: SIDDONS Robert Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1923

8. AGE: Years	Months	Days	If less than one day
22	11	8	hrs. min.

9. Birthplace: Platte, South Dakota (Town, county, and state)
10. Usual occupation: Midshipman, U.S.N.
11. Industry or business

FATHER
12. Name: Glenn R. Siddons,
13. Birthplace: Kimball, South Dakota

MOTHER
14. Maiden name: Ruth Jackson,
15. Birthplace: Ipswich, South Dakota

16. Informant: U.S.Naval Hospital,
Address: Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 14/46 (month) (day) (year)
Cemetery or crematory:
Location: Platte South Dakota
18. Funeral director: B L Hopkins
Address: Annapolis, Md.

19. March 14 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11 1946, at 3.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11 1946 to 3/11 1946 and that I last saw him alive on 3/11 1946

Immediate cause of death	DURATION
Injuries multiple Extreme Skull Fracture, Fracture, Compound, Rt. thigh	
Due to Fall from height	30 min
Due to	
Other conditions Shock, & exsanguination	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Date of
Where did injury occur? Naval Academy — Annapolis, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where)? Naval Academy
Means of injury Fall Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: U.S. Naval Hospital Date signed:

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-f)

CERTIFICATE OF DEATH

02331

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 Monticello Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Irene Edna Simpson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jesse G. Simpson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 15th 1884

8. AGE: Years 61 | Months 9 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Highland Falls N. Y. (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Townshend Drew
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Jesse G. Simpson
Address 183 Monticello Ave Annpls Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 19th 1946 (month) (day) (year)
Cemetery or crematory All Hallows
Location Davidsonville R R 2 Md.
18. Funeral director John M. Taylor's Son
Address Annapolis Md.
19. March 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946, at 5:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4, 1946, to Mar. 16 1946 and that I last saw her alive on Mar. 15 1946

Immediate cause of death	DURATION
Hemothorax	1 wk.
Due to Metastatic Carcinoma	3 Mo.
Due to Carcinoma of Uterus	2 yrs.
Other conditions Thrombophlebitis, Rt leg	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Uterus Date of op. 1945
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James R. Martin, M.D.
M. D. or other
Address 15 Prince George St. Annapolis, Md. Date signed 3-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

02332

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. County

City or town Furnace Rd. Linthicum Hights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A. County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Funnace Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John P. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Sophia L. Smith

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 23, 1877

8. AGE: Years	Months	Days	If less than one day
68	9	3	...hrs. ...min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Jacob Smith

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Rebecca Unknown

15. Birthplace Germany

16. Informant Mrs. Sophia L. Smith

Address Funnace Rd. Linthicum Hights

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 29, 1946 (month) (day) (year)

Cemetery or crematory Western

Location Baltimore, Md.

16. Funeral director Frederick A. Cole

Address 1200 W. Lombard St.

19. 3-29 (Date rec'd by registrar) 19 46 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26th 1946 at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10. 1946 to March 26 1946 and that I last saw h... alive on March 26 1946

Immediate cause of death	DURATION
Cardio-Vascular Disease	1 Yr.
Due to Arterio-Sclerosis	5 Yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Chas. L. Cole Jr. M. D. or other

Address Linthicum Date signed 3-26-46

VS A15 9-45 10M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AM

III

2032 W Maple Rd
Troy MI 107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

02333

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-44

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Tyler Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Susan Grace Starr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albertus Starr
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 2d 1878

8. AGE: Years	Months	Days	If less than one day
68	1	19	hrs. min.

9. Birthplace: Pine Woods Madison Co. N.Y.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs John Buser
Address: 7 Tyler Ave Eastport Md.

17. Burial: Burial, cremation, or removal. Which?) Date thereof: Mar 24-1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor - Son
Address: Annapolis Md.

19. March 24 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 21st 1946, at 1-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1st 1946 to Mar 21 1946 and that I last saw h[er] alive on Mar 21st 1946

Immediate cause of death	DURATION
Due to Coronary Thrombosis	
Due to Arteriosclerosis C.V.	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: Eastport, Md. Date signed: 3/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

P

02334 W

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co.
City or town -Hanover.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME DENNIS WARFIELD TURNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bessie H. Turner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 22, 1864

8. AGE: Years	Months	Days	If less than one day
82	2	4	...hrs. ...min.

9. Birthplace A. A. Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Humphrey Turner
13. Birthplace A. A. Co., Md.
MOTHER 14. Maiden name Frances Warfield
15. Birthplace A. A. Co.
16. Informant Mrs. Bessie Turner
Address Hanover, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/46 (month) (day) (year)
Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.
19. 3/28 (Date rec'd by registrar) 1946 A. W. Hedreich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 3:05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 16 1946 to Mar. 26 1946
and that I last saw h.im alive on Mar. 26 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3-16-46
Due to Arteriosclerosis & Hypertension	5 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Bare Jr. M.D. M. D. or other
Address Littlestown Date signed 3-26-46

Dr. H. H. Keech Sunset Beach Annapolis 32 F

02335 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. Co.
~~City or~~ town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
~~City or~~ town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Roland & Hall Roads
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Henry G. Vogt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lula
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23 1900

8. AGE: Years: 45 | Months: 9 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Iron Worker

11. Industry or business: Maryland Dry Dock Co

FATHER
12. Name: August Vogt
13. Birthplace: Germany

MOTHER
14. Maiden name: Ulrike Rash
15. Birthplace: Germany

16. Informant: Mrs Lula B Vogt
Address: 1614 Curry St Baltimore Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 3/20/46 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem
Location: Brooklyn Md

18. Funeral director: Pulliam Coul Co Inc
Address: 1217 E Coul St

19. 3-18 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 16 1946 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1946 to March 16 1946 and that I last saw h~~im~~ alive on March 16 1946

Immediate cause of death	DURATION
Cardiac Syncope	
Due to: Bronchial Pneumonia; duration, 2 days	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Hobart Keech M. D. or other
Address: Sunset Beach Md Date signed: Mar 16 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

02336

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: FT GEO G MEADE, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
REG. HOSP., FT GEO G MEADE, MD
How long in hospital or institution? 1 Month, 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: VIRGINIA County:
City or town: NEWPORT NEWS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1227 30th STREET
(If rural, give LOCATION)
2.(a) If veteran, name war: (Soldier, U. S. Army)

3.(a) FULL NAME: LLOYD C. WHITE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: BERNICE WHITE
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 17, 1919

8. AGE: Years	Months	Days	If less than one day
27	1	20	hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name:
FATHER 13. Birthplace:
MOTHER 14. Maiden name:
MOTHER 15. Birthplace:
16. Informant: Medical Records
Address: Reg Hosp, Ft Geo G Meade, Md.
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof March 7, 1946 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: FRAZER FUNERAL HOME
Address: WASHINGTON, D. C.
19. 6 March 19 46 Frank J. Tollison (Date rec'd by registrar) FRANK J. TOLLISON, Capt., MC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 March 19 46, at 1025 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 46, to 6 March 19 46
and that I last saw him alive on 6 March 19 46
Immediate cause of death: Tuberculous Peritonitis — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: none performed
Date of op.:
Autopsy results: Tuberculous peritonitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the followlog:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Cunningham Jr. M. D. or other
Address: 8 BF Regional Hospital, Ft. Meade, Md. Date signed: 8 March 46

03134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs. 23 days

Hospital, institution, or street address where death occurred:
CROWNSVILLE STATE HOSPITAL

How long in hospital or institution? 20 yrs. 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County: AT LARGE

City or town: ----------
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ----------
(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3.(a) FULL NAME: WILSON, ARTHUR

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ida Wilson

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ---------- 1890

8. AGE: Years	Months	Days	If less than one day
56	----	---	....hrs. ....min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Hod-carrier

11. Industry or business: ----------

FATHER
12. Name: Sonny Wilson
13. Birthplace: Georgia

MOTHER
14. Maiden name: ----------
15. Birthplace: Georgia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13-46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt Hospital

Address: Crownsville Md

19. 4/13 19 45 E.F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1946 at 5:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1926 to March 30 1946 and that I last saw him alive on March 30 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	Known to us since 3/28/46
Due to	
Due to	
Other conditions: Mental Deficiency With Psychosis (Incinde pregnancy within 3 months of death)	Known to us since 3/3

Major findings of operations: ----------

Date of op.: ----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work?

23. SIGNATURE: Albert J. Strickroder M. D. or other

Address: Crownsville, Maryland Date signed: 3/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 023378

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, residence of mother)
State: Maryland County: ———
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 South Bethel Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: WREN - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years	Months	Days	If less than one day
57	unknown		——— hrs. ——— min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: Sam Wren
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Elizabeth Watson
MOTHER 15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar. 9, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Brooklyn, Maryland
18. Funeral director: Mrs. Ida Bailey
Address: 1421 East Jefferson St., Balto., Md.
19. Mar 6 (Date rec'd by registrar) 1946 E. F. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1946 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13 1946 to March 6 1946 and that I last saw him alive on March 5 1946

	DURATION
Immediate cause of death: General Paresis	Known to us since 2/13/46
Due to: ———	
Due to: ———	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ———
Date of op. ———
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Robert J. Windsor M. D. or other
Address: Crownsville, Maryland Date signed: 3/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03135

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anundel County
City or town: Severna A.A. Co
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anundel.
City or town: Severna
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nikkie Zaukus

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	married

6.(b) Name of husband or wife: Joseph
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: Lith (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Lith

MOTHER
14. Maiden name: ?
15. Birthplace: Lith

16. Informant: Joseph Kasunskas Son
Address: 662 Washington Blvd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-26-46 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: Anundel County

18. Funeral director: Joseph Kasunskas Son
Address: 662 Washington Blvd

19. 3/26 1946 (Date rec'd by registrar) A.W. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22nd 1946, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/9/45 1945, to 3/22/46 1946
and that I last saw h.. alive on 3/21/46 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Arteriosclerosis	
Due to: Chronic Endocarditis	Unknown
Other conditions: Chronic Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Alexander M. D. or other
Address: Glen Burnie, Md. Date signed: 3/22/46